State of Hawaii
Department of Health

APPLICATION FOR RADIATION FACILITY LICENSE

License is required by Title 11, Administrative Rules, Department of Health, Chapter 45, Radiation Control.

Part I. Doing-Business-As (DBA)			**Part II. Business Information (i.e. Inc., LLC)**		
Name of Facility:			**Name of Facility:**		
Street Address:			**Street Address:**		
City:	**State:**	**Zip Code:**	**City:**	**State:**	**Zip Code:**
Mailing Address:			**Mailing Address:**		
City:	**State:**	**Zip Code:**	**City:**	**State:**	**Zip Code:**
Phone:	**Fax (Optional):**		**Phone:**	**Fax (Optional):**	
E-Mail Address (Optional):			**E-Mail Address (Optional):**		

Part III. Responsible Personnel (attach additional sheets as needed)	
Facility Compliance Contact (Required):	**Facility Inspection Contact:**
Person Responsible for Radiation Safety (Required):	**Other:**

Part IV. Radiation Producing Equipment (attach additional sheets as needed)

Manufacturer/Make:	**Control Model No.:**	**Control Serial No.:**	**Control Manufacture Date:**	**Location:**	**Purpose/Use** (Diagnostic/Screening/Etc.)

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Part V. Radiation Facility License Fee Schedule

Indicate all categories for which a license is requested:

☐ Chiropractic x-ray facility	$50	☐ Podiatry x-ray facility	$30
☐ Dental x-ray facility with 1-4 units	$30	☐ Radiation therapy facility	$100
☐ Dental x-ray facility with 5+ units	$50	☐ Veterinary x-ray facility	$30
☐ Industrial radiography (electronic)	$50	☐ Other radiation facility not listed	$30
☐ Medical x-ray facility with 1-4 units	$50		
☐ Medical x-ray facility with 5-7 units	$100		
☐ Medical x-ray facility with 8+ units	$150		

RADIATION FACILITY LICENSE FEE: $

****** For facilities with multiple categories, the license fee shall be the fee for the single highest dollar value category.***

I declare that all the information appearing on this application is accurate and true to the best of my knowledge.

X_____
Signature of facility owner / lessee / user / authorized agent

_____
Print Name/Position

_____
Date

Please make checks payable to: ***STATE DEPARTMENT OF HEALTH***

Return this application with the appropriate attachments to:

Indoor and Rad Health Branch
591 Ala Moana Blvd., Rm. 133
Honolulu, Hawaii 96813-4921

All fees are non-refundable. There will be a service fee of $25.00 for any check dishonored by the bank.
If you have any questions call our office at (808) 586-4700.

FOR OFFICE USE ONLY:

Date Received: ☐ Fee Paid $ ☐ Receipt Number: ☐

License(s) Number(s):

Chiropractic	☐	Podiatry	☐
Dental	☐	Therapy	☐
Hospital	☐	Veterinary	☐
Industrial	☐	Other	☐
Medical	☐		

APPLICATION: APPROVED / DISAPPROVED

LICENSE EXPIRES:

REVIEWED BY: ☐ DATE: ☐

Form IRHB-RAD100A.2 07/11